The last three patients: general medicine (Patient Two)

BY JONATHAN REES

For the second reflection in this series, Professor Jonathan Rees recounts his experiences of the last patient he saw as a medical registrar, telling the tragic story of a young man's death and the risks that come with diagnosis.

It hasn't happened to me often – maybe on only a handful of occasions – but often enough to recognise it, and dread it. I am talking to a patient, trying to second guess the future (how likely is it that their melanoma might stay away forever, for instance), and I find myself mouthing words that a voice in my head is warning me I will regret saying. The voice is not so much following my words, but anticipating them, so I cannot cite ignorance as an excuse – nor is it a whisper or unclear in any way, and yet I still charge on. A moment later, regret will set in.

The patient was a young man in his early 20s who lived with his mother, just the two of them at home. He had dark curly hair, was of average height, and he lived for running. This was Newcastle, in the time of Brendan Foster and Steve Cram. He had been admitted with pyrexia, chest pains, and a cough. He had bacterial pneumonia, and although he seemed pretty sick, none of us were worried about him.

After a few days he seemed no better and so we switched antibiotics – medics reading this will know why. He started to improve within a day or so, and we felt we were in charge, pleased with, and confident of our decisions. This was when I spoke with his mother, updating her on his progress. Yes, he had been very ill. Yes, we were certain about his diagnosis. And yes, the change of antibiotics and his response was not unexpected. Trying to reassure her, I said that young, fit people don't die from pneumonia anymore. That was it. All the demons shattered.

At the time, I was a medical registrar, and I supervised a junior house officer and a senior house officer. In turn, my boss was a consultant physician who looked after general medical patients, but his primary focus was clinical haematology. In those days, the norm was for all of a consultant's patients to be managed on their own team ward. On our ward, maybe half the patients were general medical, and the others had haematological diseases. Since I was not a haematologist, I was solely tasked with looking after the general medical patients, and mostly acted without the need for close supervision (in a way that was entirely appropriate).

One weekend, I was doing a brief business ward round on a Sunday morning. Our young man with pneumonia was doing well, his temperature had dropped, and he was laughing and joking. We would have been making plans to let him home soon. The only thing of note was that the houseman reported that the patient had complained of some pain in one calf. I had a look and although the signs were at best minimal, I wondered whether he could have had a deep vein thrombosis (DVT). Confirmatory investigations for DVTs in those days were unsatisfactory and not without iatrogenic risk, whilst the risks from anticoagulation in a previously fit young man with no co-morbidities are minimal. We started him on heparin.

A few days later he was reviewed on the consultant's ward round. I knew that the decision to anti-coagulate would (rightly) come under review. The physical signs once subtle were now non-existent, and the anticoagulation was stopped. A reasonable decision I knew, but one that I disagreed with, perhaps more because of my touchy ego than deep clinical judgement.

Every seven to 10 days or so I would be the resident medical officer (RMO), meaning I would be on call for unselected medical emergencies. Patients might be referred directly to us by their general practitioner, or as walk-ins via casualty (E&A). In those days we would usually admit between 10 and 15 patients over a 24-hour period, and we might also see a further handful of patients who we judged did not require hospital admission. Finally, since we were resident, we continued to provide emergency medical care to the whole hospital, including our own preexisting patients.

It was just after 8:30am. The night had been quiet, and I was in high spirits as this was the last time I would act as an RMO. In fact, this was to be the last day of me being a medical registrar. Shortly after, I would leave Newcastle for Vienna and start a career as an academic dermatologist, a career path that had been planned many years before.

The clinical presentation approaches that of a cliché. A patient with or without various risk factors, but who has been ill from one of a myriad of different conditions, goes to the toilet to move their bowels. They collapse, breathless, and go into shock. CPR may or may not help. A clot from their legs has broken free and blocked the pulmonary trunk. Sufficient blood can no longer circuit from the right side of the heart to the left. The lungs and heart are torn asunder.

When the call went out, as RMO, I was in charge. Nothing we did worked. There is a time to stop, and I ignored it. One of my colleagues took the decision. Often with cardiac arrests, you do not know the patient – that helps. Often the call is about a patient who is old and with multiple preexisting co-morbidities – that is easier, too. But I knew this man, or boy, and his mother.

That was the last patient I ever saw in general medicine.

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